AVANGRID

energize

Your BENEFITS, Your LIFE

Open Enrollment 2017

OCTOBER 24 – NOVEMBER 4, 2016

FOR FULL-TIME UIL NON-UNION EMPLOYEES

what's **inside**

Where to Go for More Information

Call the Benefits Service Center, Monday through Friday, 8:00 a.m. to 6:00 p.m. ET, at **866-981-3130**.

Go online to **www.buckhrsolutions.com/avangrid** anytime.

Availability of Summary Health Information Required Under Health Care Reform

The AVANGRID-sponsored medical plan in which you are eligible to participate may offer a number of medical coverage options. Choosing a medical coverage option is an important decision, and under the Affordable Care Act, you are required to have medical coverage. To help you make an informed choice, and to comply with the requirements of the health care reform law, Summaries of Benefits and Coverage (SBCs) are available online at www.buckhrsolutions.com/avangrid. The SBCs summarize important information about each medical coverage option in a standard format to help you compare across options. Note that you may not be eligible for each of the medical coverage options described in the SBCs. A glossary of health coverage and related medical terms used in the SBCs is available at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf.

your **enrollment** footprint

It's annual enrollment time (October 24 – November 4, 2016)!

That means it's time to review your options and actively enroll. Read this Enrollment Guide along with your 2017 Personalized Enrollment Worksheet to determine what's right for you and your family and view your cost for coverage. Then follow these steps:

WHAT YOU NEED TO DO . . .	NO LATER THAN
Consider the High Deductible Health Plan with the Health Savings Account.	November 4, 2016
Enroll online at **www.buckhrsolutions.com/avangrid** or by phone at **866-981-3130**.	November 4, 2016
• *If you decline medical and/or dental coverage,* complete a Waiver Form and submit it to the Benefits Service Center by fax or mail. • You can find the Waiver Form on **www.buckhrsolutions.com/avangrid** under Benefit Documents & Forms.	November 25, 2016
• *If you add a new dependent*, provide documentation to the Benefits Service Center.	November 25, 2016
• *If you are enrolling in the High Deductible Health Plan for the first time,* open a Health Savings Account at Wepawaug-Flagg Federal Credit Union. To do so, complete the required application forms and make a $5.00 deposit.	November 25, 2016
Review the confirmation statement you receive in the mail.	Immediately upon receipt
Keep your beneficiary information up to date. You can find the Life Insurance Beneficiary Form on **www.buckhrsolutions.com/avangrid** under Benefit Documents & Forms.	Whenever you have a change in your family – marriage, birth, death, divorce
If you have a qualifying change in family status, make a change in your election by going on-line or by calling the Benefits Service Center.	Within 30 days of the qualifying change

Most Benefits DO NOT Renew Automatically

If you do not actively enroll for 2017 coverage by November 4, 2016, you will have **no** coverage for:

- Medical
- Dental
- Vision
- Buy-up LTD
- FSAs or HSA
- Vacation Purchase

In addition, you will **not** be eligible for any "waive" credits.

You will **only** have basic life and AD&D, supplemental life (if you have already elected it) and basic LTD.

Good to Know: myCigna.com

Enjoy a simple way to personalize, organize and access your important plan information.

Register on myCigna.com. Once you do, you can log in anytime, anywhere to:

- **Manage** and track claims
- **View** ID card information
- **Find** doctors and compare cost and quality ratings
- **Review** your coverage
- **Track** your account balances and deductibles
- **Refill** your prescription drugs online and check order status with Cigna Home Delivery Pharmacy℠

What's New

We regularly review our benefits programs to ensure that they continue to deliver value to you and your family. Here are the highlights of what's new for 2017:

- There is no increase in the amount you pay for medical, dental or vision coverage.
- The annual maximum in the Dental Plans is increasing by $500 per person per year. You'll receive a greater benefit for the same cost.
- Under the Cigna medical plans, certain generic medications that you take for preventive reasons will have no out-of-pocket cost – not even a copay. Preventive generics include drugs that treat health conditions and diseases like asthma, high blood pressure, high cholesterol, diabetes, osteoporosis, as well as prenatal vitamins. You can find a list of the eligible generic preventive medications on **myCigna.com**.
- Your plan includes a new maintenance medication program called Cigna 90 Now. If you choose to fill your prescription in a 90-day supply, you may continue to use the Cigna Home Delivery Pharmacy **or** you may use a retail pharmacy in your plan's network. **Note that only a subset of retail pharmacies is included in the Cigna 90 Now network.** You can find a list of participating Cigna 90 Now retail pharmacies on **myCigna.com**.
- 3-D mammograms will be covered like any other routine mammogram. Also called breast tomosynthesis, 3-D mammography is an FDA-approved advanced technology that takes multiple images, or X-rays, of breast tissue. Traditional mammography obtains just a single image. Go to **www.buckhrsolutions.com/avangrid** to see benefit details.
- Cigna Telehealth Connection can provide you with the care you need – including most prescriptions – for a wide range of minor conditions. You can connect with a board-certified doctor via secure video chat or phone, without leaving your home or office.

  Two services provide this coverage: AmWell and MDLIVE.

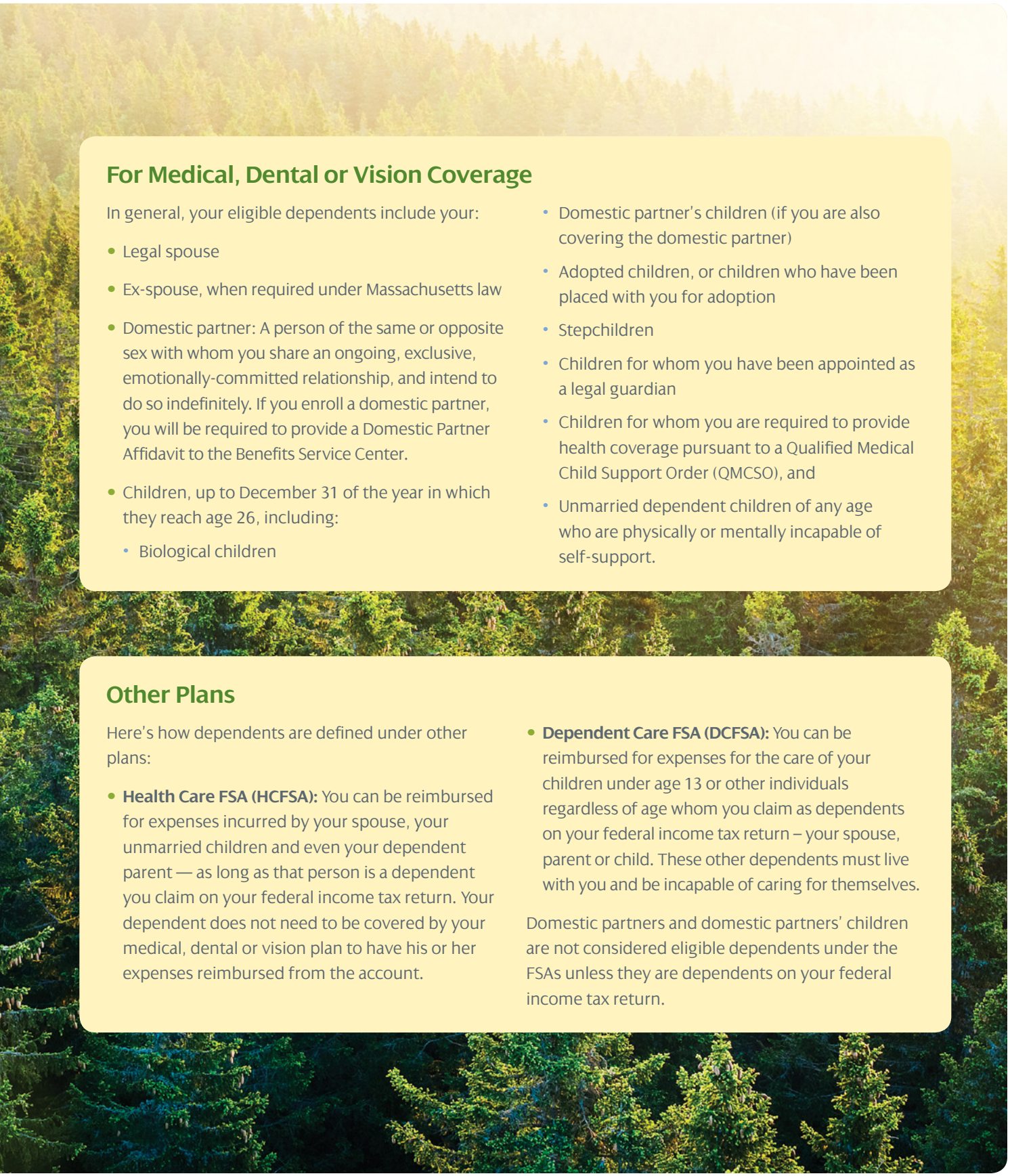
  Register for one or both of these Cigna Telehealth Services so this coverage is available when you need it:

  AmWellforCigna.com
  855-667-9722

  MDLIVEforCigna.com
  888-726-3171

who's **eligible** for coverage

The benefits and programs described in this Guide are available to all full-time AVANGRID Non-Union employees of UIL Corporate and their eligible dependents. Benefit options may vary for part-time AVANGRID Non-Union employees. If you work part-time and have questions about your benefits, please contact the Benefits Service Center at **866-981-3130**.



For Medical, Dental or Vision Coverage

In general, your eligible dependents include your:

- Legal spouse
- Ex-spouse, when required under Massachusetts law
- Domestic partner: A person of the same or opposite sex with whom you share an ongoing, exclusive, emotionally-committed relationship, and intend to do so indefinitely. If you enroll a domestic partner, you will be required to provide a Domestic Partner Affidavit to the Benefits Service Center.
- Children, up to December 31 of the year in which they reach age 26, including:
  - Biological children
  - Domestic partner's children (if you are also covering the domestic partner)
  - Adopted children, or children who have been placed with you for adoption
  - Stepchildren
  - Children for whom you have been appointed as a legal guardian
  - Children for whom you are required to provide health coverage pursuant to a Qualified Medical Child Support Order (QMCSO), and
  - Unmarried dependent children of any age who are physically or mentally incapable of self-support.

Other Plans

Here's how dependents are defined under other plans:

- **Health Care FSA (HCFSA):** You can be reimbursed for expenses incurred by your spouse, your unmarried children and even your dependent parent — as long as that person is a dependent you claim on your federal income tax return. Your dependent does not need to be covered by your medical, dental or vision plan to have his or her expenses reimbursed from the account.
- **Dependent Care FSA (DCFSA):** You can be reimbursed for expenses for the care of your children under age 13 or other individuals regardless of age whom you claim as dependents on your federal income tax return – your spouse, parent or child. These other dependents must live with you and be incapable of caring for themselves.

Domestic partners and domestic partners' children are not considered eligible dependents under the FSAs unless they are dependents on your federal income tax return.

you have the power to choose the medical plan that's right for you

You have three medical plan options:

- High Deductible Health Plan (HDHP)
- Open Access Plus $20/$500 Core Plan, and
- Open Access POS Plan

What's the Same

- The administrator is Cigna for all three plans. To find a network provider in your area, go to **www.mycigna.com**.
- The same services are covered in all three plans.
- How much you pay depends on whether you use in- or out-of-network providers.
- Each plan includes prescription drug coverage through Cigna.
- Preventive care, including certain preventive generic prescription drugs, is free when you use an in-network provider.

What's Different

	HIGH DEDUCTIBLE HEALTH PLAN (HDHP)	OPEN ACCESS PLUS $20/$500 CORE PLAN	OPEN ACCESS POS PLAN
How much you pay: From your paycheck	$*	$$*	$$$*
When you seek medical care	$$$*	$$*	$*
How you pay for in-network medical and prescription drugs (not for preventive care)	You pay the full cost out of pocket until you meet the deductible; then the plan pays 100% of eligible expenses. If you are covering dependents – that is, if you have enrolled in Dual or Family coverage – you must meet the full family deductible before the plan begins to pay benefits.	You pay a copay; then the plan pays 100% of eligible expenses.	
If you have an HSA with a Company contribution	Yes	No	No

** The actual per paycheck cost to you is shown on your enclosed personalized worksheet, and the cost you pay when you seek care is shown in the Medical Plan Comparison Grid on pages 10 and 11.*

Get the Most out of Your Benefits

- Use your preventive care benefits (physicals, screening tests, etc.). There's no cost to you for preventive care if you use an in-network provider.
- Choose in-network providers.
- Be smart about where you go for care. Rather than going to the ER for a non-life-threatening issue, consider a walk-in or urgent care clinic.
- If your doctor prescribes a medication, ask if a generic is available.
- The EAP, available 24/7, provides up to eight free and confidential counseling sessions to help you with a range of issues in your personal and professional life. EAP services also include financial counseling, elder care assistance, and referral services. Call **800-252-4555**.

be **empowered:** consider the High Deductible Health Plan

You may be tempted to go with one of the traditional options – one of the Open Access plans – because that's what you are used to. But you should consider the HDHP. Why? This plan features a new approach to health care that helps you save money when you make smart choices.

With the HDHP, you have access to a special account called a Health Savings Account (HSA). Your HSA is like a personal savings account for qualified health care costs, including medical, dental and vision costs.

Top Six Things to Know about an HSA

1. You contribute pre-tax money to your HSA, and AVANGRID contributes tax-free funds to your account. The table below shows what AVANGRID will contribute and how much you can contribute in 2017.

	THE COMPANY WILL AUTOMATICALLY CONTRIBUTE . . .*	YOU MAY CONTRIBUTE AN ADDITIONAL . . .	UP TO A MAXIMUM OF . . .
Single If you are age 54 or younger	$1,000	$2,400	$3,400
Dual or Family If you are age 54 or younger	$2,000	$4,750	$6,750
Single Catch-up contribution if you are age 55 or older	$1,000	$3,400	$4,400
Dual or Family Catch-up contribution if you are age 55 or older	$2,000	$5,750	$7,750

* *Distributed in equal installments per pay period throughout the year.*

2. HSAs have triple tax savings: You contribute pre-tax funds, earn tax-free interest, and make tax-free withdrawals for qualified health care expenses.
3. There is no "Use It or Lose It" rule. Unlike the Health Care Flexible Spending Account, funds in your HSA roll over from year to year.
4. You own the account. Your HSA contribution and even the Company contribution are yours to keep from the time they are deposited, even if you leave AVANGRID or retire.
5. You can pay for your qualified dependents' health care costs even if you do not cover them under AVANGRID's plans. However, you can't use the funds in your HSA for reimbursement and be reimbursed for the same expenses from another qualified tax-advantaged account such as an HRA or a Health Care FSA. Qualified dependents include your spouse, your children, and even a dependent parent -- anyone whom you claim as a dependent on your tax return. Your dependent does not need to be covered by your medical, dental or vision plan to have his or her expenses reimbursed from the HSA.
6. If you use the funds in your account for nonqualified expenses before age 65, you will pay income taxes and a penalty. If you use the funds for nonqualified expenses once you reach age 65, you will owe income taxes – but no penalty. This treatment is the same as funds in your 401(k).

See page 20 for instruction on opening your HSA.

Note: *The IRS sets HSA rules, including who can have one, what you can spend the money on, and how much you can contribute to the account. If you are enrolled in Medicare, you are not eligible to enroll in the HDHP or the HSA.*

Medical Plan Comparison Grid

MEDICAL	HIGH DEDUCTIBLE HEALTH PLAN WITH HSA	
	In-Network	Out-of-Network
UIL HSA Contribution	$1,000 Single; $2,000 Dual/Family	
Annual Deductible	$1,500 Single $3,000 Dual/Family	$2,500 Single $5,000 Dual/Family
Annual Out-of-Pocket Maximum	$1,500 Single $3,000 Dual/Family	$4,000 Single $8,000 Dual/Family
Preventive Care Routine physical exams, well child care, immunizations for children, routine gynecological care, routine mammograms	100%, **NO** deductible	80%, after deductible
Physician Office Visits	100%, after deductible	80%, after deductible
Maternity Care	100%, after deductible	80%, after deductible
Inpatient Hospital Stay	100%, after deductible	80%, after deductible
Outpatient Surgery	100%, after deductible	80%, after deductible
Diagnostic Services MRI, CAT Scans, PET Scans	100%, after deductible	80%, after deductible
Ambulance	100%, after deductible	80%, after deductible
Emergency Room	100%, after deductible	80%, after deductible
Urgent Care Center	100%, after deductible	80%, after deductible
Mental Health and Substance Abuse Inpatient	100%, after deductible	80%, after deductible
Outpatient	100%, after deductible	80%, after deductible
Prescription Drugs Retail* (30-day supply)	100%, after deductible	80% after deductible
Prescription Drugs Mail Order* (90-day supply)	100%, after deductible	80% after deductible
Preventive Generic Prescription Drugs	100%, **NO** deductible	80% after deductible

**Prescription drug coverage is limited to prescriptions on the approved formulary. To find this list, log on to myCigna.com.*

OPEN ACCESS PLUS $20/$500 CORE PLAN		OPEN ACCESS POS PLAN	
In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
N/A		N/A	
None	$2,000 Single $4,000 Dual/Family	None	$250 Single $500 Dual/Family
$6,600 Single $13,200 Dual/Family	$8,000 Single $16,000 Dual/Family	$6,600 Single $13,200 Dual/Family	$1,000 Single $2,000 Dual/Family
100%	70%, after deductible	100%	80%, after deductible
100%, after $20 copay	70%, after deductible	100%, after $20 copay	80%, after deductible
100%	70%, after deductible	100%	80%, after deductible
100%, after $500 copay	70%, after deductible	100%	80%, after deductible
100%, after $75 copay for surgery	70%, after deductible	100%, after $50 copay	80%, after deductible
100%	70%, after deductible	100%	80%, after deductible
100%	100%	100%	80%, after deductible
100%, after $50 copay	100%, after $50 copay	100%, after $25 copay	100%, after $25 copay
100%, after $25 copay	100%, after $25 copay	100%, after $20 copay	100%, after $20 copay
100%, after $500 copay	70%, after deductible	100%	80%, after deductible
100%, after $20 copay	70%, after deductible	100%, after $20 copay	80%, after deductible
100%, after $10 copay generic, $20 copay brand, $35 copay non-preferred brand	70% after deductible	100%, after $5 copay generic, $20 copay brand, $35 copay non-preferred brand	80% after deductible
100%, after $20 copay generic, $40 copay brand, $70 copay non-preferred brand	70% after deductible	100%, after $10 copay generic, $40 copay brand, $70 copay non-preferred brand	80% after deductible
100%	70% after deductible	100%	80% after deductible

something to **smile** about

You have two dental plan options, both provided through Delta Dental of NJ:

- Dental Plan A
- Dental Plan C

Keep in mind that if you waive coverage and later re-enroll, you can only elect Dental Plan C for one year. Once you have been enrolled in Dental Plan C for a year, you will become eligible for Dental Plan A.

While you may use any fully licensed dentist, you will maximize benefits and reduce paperwork by using a Delta Dental participating dentist.

Participating dentists will be paid directly by Delta Dental for covered services so you don't need to file a claim. However, because non-participating dentists will bill you directly, you must pay for your services out of pocket and then file a claim with Delta Dental for reimbursement.

	DENTAL PLAN A	DENTAL PLAN C
Calendar Year Deductible Per Person	$50	$75
Family maximum	$150	$225
Preventive and Diagnostic (no deductible) • Exams, bitewing x-rays (twice per calendar year) • 4 cleanings of any type per person per calendar year (routine and/or periodontic) • Fluoride treatment (once per calendar year to age 19) • Sealants	100%	100%
Remaining Basic (after deductible) • Fillings, extractions and root canals (endodontics) • Periodontal, oral surgery • Repair of dentures and removable prosthodontics	80%	80%
Crowns and Prosthodontics (after deductible) • Crowns, onlays and gold restorations	50%	50%
• Bridgework, full and partial dentures	50%	50%
• Implants	50%	N/A
Calendar Year Maximum (per person)	$3,000	$2,000
Lifetime Maximum (per person)	Unlimited	Unlimited
Orthodontia (adults and children) • Coinsurance	50%	N/A
• Lifetime maximum	$1,500	N/A

Find a Dentist

To find a Delta Dentist in your area, go to **www.deltadentalnj.com**.

see the **savings**

Each of the Cigna medical plans provides an annual routine eye exam with an in-network provider as well as a discount on eye wear. When you see a Cigna Vision Network eye care professional, you can save 20% or more on additional frames and/or lenses, including lens options, with a valid prescription. This savings does not apply to contact lens materials. See your Cigna Vision Network eye care professional for details.

If you are not covered by a Cigna medical plan or if you prefer additional coverage, you may choose to elect vision coverage through EyeMed. Through EyeMed, you can see a provider of your choice, and you will have the opportunity to save money when you use an EyeMed network provider.

EyeMed Vision Benefits at-a-Glance

COVERED SERVICES	IN-NETWORK
Eye Exam *Once every 12 months*	
• With dilation as necessary	$10 copay
• Standard contact lens fit and follow-up	Up to $40
• Premium contact lens fit and follow-up	10% off retail
Retinal Imaging Benefit	Up to $39
Frames *One every 24 months* *Any available frame at provider location*	$130 allowance, 20% off amount over $130
Standard Plastic Lenses*	
• Single vision • Bifocal • Trifocal • Lenticular	$0 copay
Contact Lenses* *Contact lens allowance includes materials only*	
• Conventional	$0 copay, $130 allowance, 15% of amount over $130
• Disposable	$0 copay, $130 allowance
• Medically Necessary	$0 copay
Laser Vision Correction Lasik or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price
Additional Pairs Benefits	40% off eyeglass purchases

*Lenses or contact lenses once every 12 months

Find an In-Network Vision Provider

To find a Cigna vision provider in your area, go to https://cigna.vsp.com.
To find an EyeMed vision provider in your area, go to www.eyemedvisioncare.com.

looking for ways to **save** money?

use flexible spending accounts!

The Flexible Spending Accounts (FSAs), administered by WageWorks, allow you to pay for eligible health care and dependent care expenses on a pre-tax basis. Because the money you put into FSAs is contributed on a pre-tax basis, you lower your taxable income, which saves you money.

If you enroll in the HDHP, you cannot elect a Health Care FSA, because you are already eligible to contribute to an HSA. You cannot have both.

You may contribute up to $2,550 a year to the Health Care FSA and up to $5,000 a year to the Dependent Care FSA. If you wish, you may contribute to both accounts. **Note: You must re-enroll in the FSAs each year if you wish to participate, even if you are currently participating.**

Eligible FSA Expenses

For a complete list of eligible and ineligible Health Care and Dependent Care FSA expenses, see Publications 502 and 503 on the IRS website at www.irs.gov/pub/irs-pdf/p502.pdf (Health Care FSA) or www.irs.gov/pub/irs-pdf/p503.pdf (Dependent Care FSA).

Health Care FSA

You can use the Health Care FSA to pay for eligible medical, dental and vision expenses incurred by **you and your eligible dependents**, even if you or your dependents are not enrolled in a UIL medical option. Eligible dependents are described on page 6.

Examples of eligible expenses include: deductibles, copays and coinsurance under the medical, dental and vision plans, as well as certain over-the-counter drugs, eye surgery, hearing aids, wheelchairs, acupuncture and chiropractic treatment.

Dependent Care FSA

You can use the Dependent Care FSA to pay **eligible dependents' day care expenses** that you incur in order to go to work, as long as your spouse, if you are married, also works, is a full-time student or is disabled. Eligible dependents are described on page 6.

Eligible expenses include: day care, nursery schools, babysitting expenses during your working hours and adult dependent care and elder care. **Note: Your dependents' eligible health care expenses must be submitted to the Health Care FSA, not to this account.** To file a claim for reimbursement, you will be required to provide a Social Security or tax ID number for your dependent care provider.

Using an FSA Is as Easy as 1-2-3

1. Decide how much to contribute. To get help estimating your annual out-of-pocket health care and/or dependent care expenses, use the FSA calculator on the left navigation bar of the Benefits Service Center website at **www.buckhrsolutions.com/avangrid**. After you enroll, your pre-tax contributions will be deducted from your pay each pay period and credited to your account before federal, state and, in most cases, local income taxes are calculated.
2. Pay for your health care and/or dependent care expenses.
3. Request reimbursement for eligible health care and dependent care expenses. Complete an FSA claim form and fax it, along with your itemized receipts, to WageWorks. Health care and dependent care forms are available on the Benefits Service Center website at **www.buckhrsolutions.com/avangrid** under Benefit Documents and Forms. The WageWorks customer service number is **877-924-3967**.

Important Notes:

- Claims incurred for a given year must be submitted by June 30 of the following year.
- The Health Care FSA reimburses eligible expenses up to the amount you choose to set aside over the entire year – regardless of how much you have actually saved in your account at the time the claim is received. However, the Dependent Care FSA reimburses only up to the account balance on the day your claim is received. Claims exceeding the balance will be reimbursed once there is enough money in the account to cover them.
- If you stop working for the Company or you retire, you can claim reimbursement only for services that you incurred before your date of termination or retirement. Claims for these expenses must be submitted for reimbursement before June 30 of the following year.

Use It or Lose It

When you enroll in an FSA, estimate your expenses carefully. According to IRS rules, if you do not incur enough expenses by year-end to use up all the money in your account(s), you will forfeit your remaining balance. In other words, "use it or lose it." This is different than the rules for an HSA, which rolls over any unused funds year after year.

back-ups

AVANGRID's benefits protect you and your family financially in the event of unforeseen circumstances.

Basic Life and Accidental Death & Dismemberment Insurance

AVANGRID automatically provides basic life and accidental death & dismemberment (AD&D) insurance coverage at no cost to you, through The Hartford, as shown below:

BASIC LIFE	BASIC AD&D
1x your annual base salary, rounded up to the next $1,000, up to a maximum of $150,000	1x your annual base salary, rounded up to the next $1,000, up to a maximum of $1,000,000
Pays a benefit to your beneficiary if you die while covered by the plan	Pays an additional benefit to your beneficiary if you die as the result of an accident, or a benefit if you suffer certain serious injuries

Supplemental Life Insurance

If you need more life insurance than the Company provides under its Basic Life Insurance plan, you may purchase supplemental life insurance coverage of one, two, three, four or five times your annual base salary, up to a maximum of $1 million. Your rates for this coverage are based on your age and salary, and are shown on your Enrollment Worksheet.

If you are newly eligible for benefits, you can elect from one times to five times your annual base salary with no Evidence of Insurability. If you are already eligible for benefits but it is your first time enrolling for supplemental life insurance coverage, you can elect only one times your annual base salary. If you already have coverage, you can increase your life insurance by one level during Open Enrollment. In either case, you must provide Evidence of Insurability (EOI).

If you need to provide EOI, The Hartford will send you a letter containing EOI instructions for the required online application and health questionnaire. Complete the application and return it to The Hartford as soon as possible. The application process will close on **March 31, 2017**, and any applications that are pending at that time will be denied. The next opportunity to apply for supplemental life insurance will be during the 2018 Open Enrollment period. Your increase in coverage will not become effective until your EOI information has been approved by The Hartford.

Disability Benefits

AVANGRID automatically provides both accumulated sick time benefits and long-term disability (LTD) insurance at no cost to you. These benefits protect your family by continuing part of your base salary if illness, disease or disability prevents you from working. Your sick time benefits are provided to you automatically and you do not need to elect them during Open Enrollment.

Basic LTD

AVANGRID provides 50% salary replacement up to a maximum benefit of $8,333 per month.

"Buy Up" LTD Coverage

You can elect to "buy up" to 60% of salary replacement to a maximum of $10,000 per month. The cost of the buy-up coverage can be found on your Enrollment Worksheet or on the Benefits Service Center website **www.buckhrsolutions.com/avangrid** when you make your elections.

If you elect to purchase the buy-up LTD insurance, after the enrollment period ends, The Hartford will send you a letter containing EOI instructions for the required online application and health questionnaire. Complete the application and return it to The Hartford as soon as possible. The application process will close on **March 31, 2017**, and any applications that are pending at that time will be denied. The next opportunity to apply for buy-up LTD insurance will be during the 2018 Open Enrollment period. Your increase in coverage will not become effective until your EOI information has been approved by The Hartford.

Vacation Purchase

To help you relax and recharge, AVANGRID offers the option to purchase one to five additional vacation days. Your total vacation – standard vacation plus any purchased vacation days – cannot exceed six weeks per calendar year. If you already receive six weeks of standard vacation, you may not purchase additional vacation days. You must use your purchased vacation days before you use your standard vacation time.

You may not carry over any unused purchased vacation days. If you do not use your days, they will be paid out as cash. If you terminate employment for any reason and have unused purchased vacation days, these days will also be paid out as cash in your final paycheck.

turn on your 2017 benefits

You have two ways to enroll:

Online

Go to **www.buckhrsolutions.com/avangrid**, 24 hours a day, seven days a week.
Note: All passwords have been reset.

- Your User ID is your 8-digit Personnel ID number. Please make sure that when entering your Personnel ID, you include all digits, including any zeros at the beginning of your ID number.
- Your default Password is the month and day of your birthday followed by the last four digits of your Social Security Number (SSN). For example, if you were born on March 1, 1975 and the last four digits of your SSN are 6789, then your Default Password is 03016789. You will be prompted to change this password when you log on.

By Phone

Call the Benefits Service Center, Monday through Friday, 8:00 a.m. to 6:00 p.m. ET, at **866-981-3130**. Be sure to have your Enrollment Worksheet handy.

Steps for Opening an HSA

- Go to **www.buckhrsolutions.com/avangrid**.
- Download and print the account activation forms from the Wepawaug-Flagg Federal Credit Union (AVANGRID's HSA administrator).
- Complete both the Wepawaug-Flagg Federal Credit Union Membership Application and the Wepawaug-Flagg Federal Credit Union Health Savings Account Application.
- Make an initial $5.00 deposit into the account. Submit the forms and your $5.00 directly to the Wepawaug-Flagg Federal Credit Union:

  Wepawaug-Flagg Federal Credit Union
  Attention: HSA Administrator
  249 West Main Street
  Branford, CT 06405
  203-786-6410

Note: Forms must be received by November 25, 2016 for you to receive the full annual contribution from AVANGRID.

If you have a balance in your 2016 Health Care FSA, you must use all the funds in your FSA – so your balance is at $0 – before you open your HSA with Wepawaug-Flagg Federal Credit Union. Remember that funds in your HSA that you don't use during the year roll over from year to year and are yours to keep, even if you leave AVANGRID.

Don't Forget!

✓ If you don't enroll, your 2016 elections will not roll over.

✓ If you decline AVANGRID's medical and/or dental coverage, you and your spouse/domestic partner, if applicable, must **complete a Waiver Form and mail or fax it to the Benefits Service Center** (Benefits Service Center, P.O. Box 14069, Cincinnati, OH 45250; Fax: 513-784-9734) **no later than November 25, 2016, to be eligible for an opt-out credit**. To get a waiver form:

- Go to **www.buckhrsolutions.com/avangrid** under Benefit Documents and Forms, or
- Call the Benefits Service Center at **866-981-3130**.

Each pay period's opt-out credits are worth:
Single: $29.08
Dual: $59.60
Family: $76.56

✓ If you are adding a new dependent to your health coverage, **you must provide documentation of your dependent's eligibility to have coverage no later than November 25, 2016.** See below for details about what's required.

✓ If you are enrolling in the HDHP for the first time, you must also open your HSA. See the previous page for information on what you need to do.

✓ After you enroll, look for your confirmation statement in the mail. Review it carefully to make sure everything is correct. If you see an error, contact the Benefits Service Center right away at **866-981-3130**.

✓ You should designate a beneficiary (or beneficiaries) for all the benefit plans that you may be enrolled in so that these benefits will be paid according to your wishes. Review your beneficiary designation once a year to be sure these assignments keep pace with any life changes. These are the benefit groups that require a beneficiary form to be on file:

- **The Hartford Life, AD&D, and Supplemental Life plans:** Beneficiary forms are available on the Benefits Service Center website at **www.buckhrsolutions.com/avangrid**, under Benefit Documents and Forms. Completed forms should be forwarded to the Benefits Service Center or faxed to **513-784-9734**.
- **Vanguard 401(k) Plan:** Beneficiary designation information is available on the Vanguard website at **www.vanguard.com**.

Documentation Required for New Dependents

If you are adding a new dependent, mail or fax the documentation outlined below to:

Benefits Service Center
P.O. Box 14069
Cincinnati, OH 45250
Fax: 513-784-9734

For a spouse, you must submit a copy of:

- Your marriage certificate, and
- Your spouse's birth certificate, and
- Your spouse's Social Security card.

For a child, you must submit a copy of:

- A birth certificate or proof of adoption or proof of legal guardianship, and
- Your child's Social Security card.

For a domestic partner, you must submit:

- A notarized Domestic Partner Affidavit, and
- A copy of your domestic partner's birth certificate, and
- A copy of your domestic partner's Social Security card.

need to make a switch?

Once you enroll for 2017 benefits, you will not be able to change your medical, dental, vision or FSA elections until the next Open Enrollment period, unless you or your dependents gain or lose eligibility as a result of a qualifying life event. If you experience one of the qualifying life events described below, you may change your benefit elections by visiting the Benefits Service Center website at **www.buckhrsolutions.com/avangrid**.

Qualifying life events include:

- Marriage, divorce, legal separation or annulment
- Birth or adoption (or placement for adoption) of a child
- Death of a covered spouse/domestic partner or child
- Loss or gain of eligibility for insurance coverage for you or a covered dependent, including the exhaustion of COBRA benefits or cancellation due to nonpayment of COBRA benefits
- Change in employment status including termination or commencement of employment, or change in work schedule (including part time to full time, or vice versa) for you, your spouse/domestic partner or your dependent
- Change in health insurance eligibility due to relocation of residence or workplace for you, your spouse/domestic partner or your dependent
- A judgment, decree or order resulting from your marriage, divorce, legal separation or change in child custody requiring you to add, or allowing you to drop, coverage for your dependents
- You or your spouse's or dependent child's entitlement to Medicare or Medicaid
- A significant increase in cost or reduction in benefits coverage under the AVANGRID plan or under your spouse/domestic partner's plan
- A change in a spouse/domestic partner's or dependent child's coverage under another plan that would permit a new election under that plan, and
- A change during the year in your dependent care provider, including the cost of your dependent care provider.

Deadline for Making Changes

You have **30 days from the date of the qualifying life event** to revise your elections. For example, if you have a baby, you have 30 days from the date of birth to add your child to your coverage. If you do not make the change within 30 days of the event, you will have to wait until the next Open Enrollment period to make the change.

Any change to your elections must be consistent with the type of qualifying life event you experience.

Special Enrollment Rights

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in an AVANGRID medical plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). You must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

The plan will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have 60 days — instead of 30 — from the date of the Medicaid/CHIP eligibility change to request enrollment in the plan. Note that this new 60-day extension doesn't apply to enrollment opportunities other than the Medicaid/CHIP eligibility change.

Also, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents in an AVANGRID plan. You must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Important Notices

Coordination of Benefits

When you have medical or dental coverage under more than one plan, claims are considered for payment as follows. Depending on who the patient is, one of the plans is primary (responsible for paying benefits first) and the other plan is secondary.

1. If you are the patient, the Company's medical coverage is primary.
2. If your spouse or domestic partner is the patient, your spouse's or domestic partner's coverage is primary.
3. For dependent child(ren), the plan of the parent with the earlier birth month and day in the year is primary.

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance providers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for a mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. Shorter hospital stays are allowed if the attending physician, after consulting with the mother, approves discharge.

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, each medical plan sponsored by AVANGRID provides coverage for the following breast reconstruction procedures in connection with mastectomies:

- All stages of reconstruction of the breast that was operated on
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Coverage is provided in a manner determined in consultation with the attending physician and the patient. The deductible and the copay requirements that apply to other covered services also apply to these post-mastectomy reconstructive and treatment services.

Privacy

Federal privacy regulations protect patient rights and define certain obligations for employers and health care providers that handle private medical information. The basis for these rules appears in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Medical Privacy Rule At-a-Glance

Information protected. Protected Health Information (PHI) means all individually identifiable health information transmitted or maintained by the medical, dental and health care spending account, whether in oral, written or electronic form. De-identified information, which is information that does not identify an individual, and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual, is not protected.

Individual rights. Patients must be given a clear written explanation of how health information will be used or disclosed. In addition, you have the right to inspect and obtain a copy of health information that may be used to make decisions about your benefits, for example, information regarding enrollment, eligibility, payment, billing, claims adjudication, appeal determinations and case or medical management record systems. You may request an amendment to records and restrictions in use, however, the plan is not required to comply with all of these requests. A complaint procedure is provided to resolve privacy violations.

Limits on use and release. In certain instances the plan may use or disclose PHI without your authorization, e.g., as needed to operate the plan or pay for covered medical expenses, or to comply with public health or law enforcement purposes, or to family members or providers involved in your primary care. Disclosures of health information are limited to the minimum amount necessary for specified purposes. In general, other disclosures of PHI may only be done pursuant to your authorization.

This is a summary of the Medical Privacy Notice, which you can find in its entirety on **www.buckhrsolutions.com/avangrid**. You may also contact the Benefits Service Center for more information.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage. An additional notice regarding eligibility for CHIP is enclosed with this Guide.

AVANGRID

This Enrollment Guide is intended to provide a general overview of the health and welfare benefits and programs that are available to AVANGRID and UIL employees, but it does not constitute an employment contract. The programs described are subject to specific eligibility requirements. If there are any discrepancies between the benefits described here and the legal plan documents, benefits will be based on the legal plan documents.

AVANGRID and UIL Holdings Corporation intend to continue the benefit plans described in this Guide indefinitely. However, because conditions may change, AVANGRID and UIL reserve the right to change, suspend or discontinue them at any time.

Questions?

Log on to the Benefits website at **www.buckhrsolutions.com/avangrid**, 24 hours a day, seven days a week.
Or, call the Benefits Service Center, Monday through Friday, 8:00 a.m. to 6:00 p.m. ET, at **866-981-3130**.

Benefits Service Center
866-981-3130
www.buckhrsolutions.com/avangrid

UILNUA/October 2016